471-000-2 Instructions for Completing Form DM-5. "Physician's Confidential Report"

Use: Form DM-5 is used by the local office/Nursing Facility to secure from the physician information needed to determine -

1. Eligibility for assistance;
2. The kind and amount of medical care or related service needed or given to a client;
3. If an assistance client has any physical or mental condition which would restrict work or training activity;
4. The initial need for care in a long term care facility; and
5. Level of care, when the physician or the facility request a change in type of service.

Number Prepared: For most purposes, one copy of Form DM-5 is completed.

When a diagnostic examination for eligibility for Aid to the Disabled or ADC-I is being requested, the local office sends a photocopy of the completed Form DM-5 to the State Review Team.

When used to determine the initial need and level of care in a long term care facility, an original and two copies are completed. The original is sent to the facility and becomes a permanent part of the client's medical record. A copy is attached to the initial Form DM-5 LTC, DM-5-MR-LTC, or MC-9NF and forwarded to the State Review Team. The local office retains one copy.

Completion: Form DM-5 is completed as follows. Local office staff or facility staff complete the heading and Items 1 and 2.

Heading: Enter all identifying information as indicated. If the client is in a nursing home, include the client's beginning eligibility date which covers this nursing home admission.

Item 1: No entry required.

Item 2: Reason for Referral: The effectiveness of information reported on this form depends largely on the phrasing in this section, e.g., if the report is needed for job support requirements, attention should be called to items 12 and 13.

A definite statement must be entered in this section.

Items 3-15: The physician completes these items.

Note: For item 7, the diagnoses contributing to the current need for care and services must be listed as primary.

Signature: The physician signs and dates Form DM-5.

Distribution: See Number Prepared.

Retention: The medical review team and local office staff retain their copies of Form DM-5 for five years after the case is closed.

# PHYSICIANS CONFIDENTIAL REPORT

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

| Recipient/Payee, Relationship, Address | Name of Patient | | |
|---|---|---|---|
| | I.D./Social Security No. | Date of Birth | Sex ☐ Male ☐ Female |
| | Admission Date | Eligibility Date | Local Office |

Name, Address and Specialty of Examining Physician

1. To the Physician: The individual named above is an applicant for or recipient of assistance. Medical findings which you are asked to report on this form are used to determine eligibility for assistance and to plan for medical care and other services. It is important that your report be specific enough to indicate the kind and extent of disability and the treatment and services required. Attach additional pertinent information including hospital admission/discharge summaries, lab reports, consultative reports/letters, psych. reports and testing, etc.

2. Reason for Referral

Name - Title/Position _____ Date _____

| 3. Diagnosis (Related to present medical condition): | Date of Onset | Anticipated Duration |
|---|---|---|
| Primary | | |
| Secondary 1. | | |
| 2. | | |
| 3. | | |

4. Prognosis, Include Rehabilitation Potential:

5. History of Present Illness - Current Medical Symptoms/Conditions (Include pertinent past medical history)

6. Specific Physical Findings (Include pertinent positive and negative findings)

Height _____ Weight _____ Pulse _____ Blood Pressure _____

A. Vision and Hearing

B. Respiratory

C. Gastro-Intestinal

D. Genito-Urinary

E. Cardio-Vascular

F. Musculo-Skeletal

G. Neurological*

*(Findings must be documented if primary diagnosis is Dementia, Alzheimers or related condition)

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(Previous version 12/94 should be used first)

7. Mental Findings: ☐ Alert ☐ Cooperative ☐ Psycho-Neurosis ☐ Psychosis ☐ Other

Is the individual competent to handle his/her own affairs? ☐ Yes ☐ No ☐ Questionable

A. Mental Status:

B. Psychological Test Results:

8. Pertinent Lab Findings: E.G., Hematology, Chemistry, EKG, X-Ray, EEG and other reports that substantiate condition. (Attach reports)

9. Diet (Results, if applicable):

10. Drugs Prescribed with Dosage and Frequency (Results, if applicable)

11. Recommended Therapy or Treatment Program or Regimen with Expected Duration:

12. Describe any Physical/Mental Conditions which would restrict work or training activities.
A. Temporary Condition(s): B. Permanent Condition(s):

13. Describe as fully as possible: Attach additional sheets as necessary

A. Limitations in activities of daily living:

B. Limitations in ability to work:

C. Specific restrictions of physical activity (Lifting, sitting, walking, standing, etc.)

14. If, in your professional judgement, this patient's physical and/or mental ability has been impaired or has deteriorated to the degree that he/she cannot be expected to function independently, please indicate below the type of service to allow state to make payment for client.)

- ☐ Homemaker Services
- ☐ Home Health Aide/Personal Care Aide Services
- ☐ Home Health Nursing Services
- ☐ Alternate Living Arrangement: Residential Care Facility, Adult Foster Home or Domiciliary Facility
- ☐ Nursing Facility Services (were needed at the time of admission and continue to be needed)
- ☐ Swing-bed services (in rural hospitals)
- ☐ ICF/MR Services
- ☐ Other (Please specify): _____

List all consultants and their specialities _____

How long has patient been under your care? _____
Date you last examined patient _____
Do you expect to continue treatment? _____

Signature of Examining Physician Date

15. Any Other Comments: